State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: __ No limitations X With limitations*

2.a. Outpatient hospital services.

Provided: __ No limitations X With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

X Provided: __ No limitations X With limitations*

__ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

X Provided: __ No limitations X With limitations*

3. Other laboratory and x-ray services.

Provided: X No limitations __ With limitations*

*Description provided on Attachment.

1. Inpatient hospital services are limited to admissions certified for payment by Nevada Peer Review Organization.

2.a. Outpatient hospital services are limited to the same extent as physicians' services, prescribed drugs, therapy and other specific services listed in this Attachment.

2.b. Rural health clinic services are subject to the same limitations listed for specific services elsewhere in this Attachment.

Rural Health Clinic (RHC) Services are defined in section 1905(a)(2)(B) of the Social Security Act (the Act). RHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the State Plan.

2.c. Federally qualified health center services are subject to the same limitation as those of rural health clinics.

Federally Qualified Health Center (FQHC) Services as defined in section 1905(a)(2)(C) of the Social Security Act (the Act). FQHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the State Plan.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: __No limitations X With limitations*

4.d Face-to-face tobacco cessation counseling services for pregnant women.

1. Provided: (i) X By or under supervision of a physician;

(ii) X By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

2. Provided: X No limitations __ With limitations*

* Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

Please describe any limitations

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: X No limitations __With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: __ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: __ No limitations X With limitations*

* Description provided on Attachment.

4.a. Nursing facility services require prior authorization from the Nevada Medicaid Office.

4.b. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services as defined in 42 CFR 440.40(b). All medically necessary diagnostic and treatment services will be provided to EPSDT recipients to treat conditions detected by periodic and interperiodic screening services, even if the services are not included in the "State Plan."

1. School Based Child Health Services

School based health services include covered medical services, treatment, and other measures to correct or ameliorate any physical or mental disability. Services are provided by or through a Local Education Agency (LEA) to children with or suspected of having disabilities, who attend public school in Nevada, recommended by a physician or other licensed practitioners of the healing arts to special education students.

Assessment, diagnosis, and evaluation services, including testing, are services used to determine Individuals with Disabilities Education Act (IDEA) eligibility or to obtain information on the individual for purposes of identifying or modifying the health related services on the Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP). These services are not covered if they are performed for educational purposes (e.g. academic testing or are provided to an individual who as the result of the assessment and evaluation is determined not to be eligible under IDEA. Services must be performed by qualified providers as set forth in this State Plan Amendment and who provide these services as part of their respective area of practice (e.g., psychologist providing a behavioral health evaluation).

Service Limitations

Services provided in a school setting will only be reimbursed for recipients who are at least three years of age and under 21 years who have been determined eligible for Title XIX and IDEA, Part B services with a written service plan (an IEP/EFSP) which contains medically necessary services recommended by a physician or other practitioner of the healing arts, within the scope of his or her practice under state law. For children ages 0-3, these direct services are available through the Early Intervention program and community providers, but are not provided in a school based setting.

Medicaid does not reimburse for social or educational needs or habilitative services. Medicaid does cover §1905(a) medical services addressed in the IEP that are medically necessary that correct or ameliorate a child's health condition. Medicaid covered services are provided in accordance with the established service limitations.

The services are defined as follows:

A. Physicians' services furnished in the school environment.

Services: As regulated under 42 CFR §440.50 and other applicable state and federal law or regulation.

Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, performed by a physician or under the personal supervision of a physician, and that are within the scope of practice of their prognosis as defined by state law. Services must be performed by the physician or by a licensed professional working under the personal supervision of the physician, such as:

a. Evaluation and consultation with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;
b. Record review for diagnostic and prescriptive services;
c. Diagnostic and evaluation services to determine a recipient's medically related condition that results in the recipient's need for medical services.

Provider Qualifications:

Licensure as a Physician by the Nevada State Board of Medical Examiners acting within their scope of practice (Nevada Revised Statue (NRS) 630.160, 630.165, 630.195, Nevada Administrative Code (NAC) 630.080), and 42 CFR §440.50

B. Physician's Assistant services furnished in the school environment.

Services: As regulated under 42 CFR §440.60 and other applicable state and federal law or regulation.

Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the personal supervision of a physician, and that are within the scope of practice of their prognosis as defined by state law. Services must be performed by the physician or by a licensed professional working under the personal supervision of the physician, such as:

a. Evaluation and consultation with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;
b. Record review for diagnostic and prescriptive services;
c. Diagnostic and evaluation services to determine a recipient's medically related condition that results in the recipient's need for medical services.

Provider Qualifications:

Licensed by the Board of Medical Examiners or certification by the Nevada State Board of Osteopathic Medicine as a Physician Assistant to perform medical services under the supervision of a supervising physician in which they perform the functions or actions, and must act only within the scope of their State license.

C. Psychologists' services furnished in the school environment.

Services: As regulated under 42 CFR §440.60(a) and other applicable state and federal law or regulation.

Observation, description, evaluation, interpretation or modification of human behavior by the application of psychological principles, methods or procedures to prevent or eliminate disease, disability, problematic, unhealthy or undesired behavior and to enhance personal relationships and behavioral and mental health towards the appropriate reduction of a mental impairment to the child's best possible functional level. Service includes:

a. Mental health assessment;
b. Psychological testing (non-educational cognitive);
c. Assessment of motor language, social, adaptive and/or cognitive functioning by standardized developmental instruments;
d. Psychotherapy (group/individual).

Provider Qualifications:

A doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the State Board of Psychologist Examiners. Licensed in the state in which they perform the functions or actions, and must act only within the scope of their State license.

D. Registered Nurses and Licensed Practical Nurses services furnished in the school environment.

Services: As regulated under 42 CFR §440.60(a) and other applicable state and federal law or regulation.

Skilled nursing refers to assessments, judgments, interventions and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of skilled nursing interventions.

Skilled nursing services are a covered service when provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse in accordance with the IEP/IFSP, to be safe and effective. An LPN may participate in the implementation of the plan of care for providing care to recipients under the supervision of a licensed registered nurse, or physician, or nurse practitioners that meet the federal requirements at 42 CFR 440.166. Services considered observational or stand-by in nature are not covered. Nursing Services are provided to an individual on a direct one-to-one basis on site within the school environment, such as:

a. Catheterization or catheter care;
b. Care and maintenance of tracheotomies;
c. Prescription medication administration that is part of the IEP/IFSP;
d. Oxygen administration;
e. Tube feedings;
f. Suctioning;
g. Ventilator Care;
h. Evaluations and assessments (RNs only).

Provider Qualifications

Nurses must be licensed by the Nevada Board of Nursing as a Registered Nurse (Nevada Revised Statutes (NRS) 632.019) or, as a Licensed Practical Nurse (NRS 632.016) in accordance with the Nurse Practice Act working within the scope of their practice.

E. Advanced Nurse Practitioners' services furnished in the school environment.

Services: As regulated under 42 CFR §440.166 and other applicable state and federal law or regulation.

Nursing evaluation and treatment services include: Assessment, treatment services, and supervision of delegated health care services provided to prevent disease, disability, other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical and mental disability and restoration of a recipient to his or her best possible functional level. Supervision for services provided to coordinating care and integrating nursing tasks and services that can be performed in a school environment, in addition to:

a. Evaluation and consultation with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;
b. Record review for diagnostic and prescriptive services;
c. Diagnostic and evaluation services to determine a recipient's medically related condition that results in the recipient's need for medical services.

Provider Qualifications

Hold a certificate of recognition as an advanced nurse practitioner by the Nevada Board of Nursing to perform medical services under the supervision of a supervising physician in which they perform the functions or actions, and must act only within the scope of their State certificate of recognition, in accordance with Nevada Revised Statutes (NRS) Chapter 632 and Nevada Administrative Code (NAC) Chapter 632, Nurse Practice Act.

F. Physical therapy services furnished in the school environment.

Services: As regulated under 42 CFR §440.110(a) and other applicable state and federal law or regulation.

Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified physical therapist to ameliorate/improve neuromuscular, musculoskeletal and cardiopulmonary disabilities.

Physical Therapy Evaluations and Treatments: includes assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the recipient receiving treatment such as:

a. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments effecting areas such as tone, coordination, movement, strength, and balance;
b. Therapeutic exercise;
c. Application of heat, cold, water, air, sound, massage, and electricity;
d. Measurements of strength, balance, endurance, range of motion;
e. Individual or group therapy.

Provider Qualifications:

A "qualified physical therapist" is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State.

Physical therapy assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing (NRS 640.260), and has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977.

All personnel who are involved in the furnishing of outpatient physical therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

The physical therapist must be present or readily available to supervise a physical therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

G. Occupational therapy services furnished in the school environment.

Services: As regulated under 42 CFR §440.110(b) and other applicable state and federal law or regulation.

Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist to ameliorate/improve functional disabilities.

Occupational Therapy Evaluations and Treatments: Include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services, such as:

a. Evaluation and diagnosis to determine the extent of disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
b. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;
c. Exercise to enhance functional performance;
d. Individual and group therapy.

Provider Qualifications:

A "qualified occupational therapist" is an individual who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

Occupational therapy assistant is a person who has satisfied the academic requirement of an educational program approved by the Board of Occupational Therapy and the American Occupational Therapy Association and is authorized (licensed or certified) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

All personnel who are involved in the furnishing of outpatient occupational therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

The occupational therapist must be present or readily available to supervise an occupational therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

H. Services for individuals with speech, hearing, and language disorders.

Services: as regulated under 42 CFR §440.110(c) and other applicable state and federal law or regulation.

Speech and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist.

The practice of audiology consists of rendering services for the measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing. Audiology services must be performed by a certified and licensed audiologist. Treatment services such as:

a. Speech and language evaluations and diagnosis of delay and/or disabilities to include voice, communication, fluency, articulation, or language development;
b. Individual or group therapy;
c. Audiological evaluation and diagnosis to determine the presence or extent of hearing impairments that affect the recipient's educational performance;
d. Complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.

Provider Qualifications:

Speech and language pathologists are required to have a State license or State certification or registration and have a certificate of clinical competence from the American Speech and Hearing Association (ASHA); have completed the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

A qualified audiologist has a master's or doctoral degree in audiology which meets State licensure requirements. Per NRS 637B.160 they are licensed by the Board of Examiners for Audiology and Speech Pathology.

I. Medical supplies, equipment, and appliance services furnished in the school environment.

Services: As regulated under 42 CFR §440.70 and other applicable state and federal law or regulation.

Durable Medical Equipment (DME) is defined as equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Disposable medical supplies are those items which are not reusable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an illness or injury.

Service limitations:

Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Deluxe equipment will not be authorized when it is determined a standard model will meet the basic medical needs of the recipient. Items classified as educational or rehabilitative by nature are not covered under this benefit. The DME provider is required to have documentation of physician's orders prior to the dispensing of any equipment or supplies.

Prior authorization and service limitations are applicable for some equipment and supplies. Specific limitations can be found in Chapter 1300 of the Medicaid Services Manual.

Provider Qualifications:

Providers dispensing durable medical equipment and medical supplies must be licensed with Medical Device Equipment and Gas through the Nevada Board of Pharmacy and be enrolled as a provider with the Division of Health Care Financing and Policy (DHCFP). Local Education Agency providers may dispense audiological supplies/equipment and medical supplies by their qualified practitioners acting within the scope of practice under state law.

Intensive Behavior Intervention

Services: As regulated under 42 CFR §440.60 and other applicable state and federal law or regulation

Services provided are for Medicaid eligible individuals under age 21 in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority. The intensive behavior intervention must be medically necessary to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of Autism Spectrum Disorder (ASD) or other condition for which intensive behavior intervention is recognized as medically necessary. All services must be provided under a treatment plan based on evidence-based assessment criteria and include realistic and obtainable treatment goals.

Service Limitations

Services provided will only be reimbursed for recipients under the age of 21 as a required component of the EPSDT benefit. Services must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN) and be directly related to the active treatment regimen designed by the healthcare professional that is clinically responsible for the treatment plan. Treatment services must be delivered by a qualified healthcare professional as defined in provider qualifications, and acting within their scope of licensure. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, or in the recipient's home.

Prior authorization and service limits are applicable for treatment services based on the individual's treatment needs as determined through and medical necessity in accordance with EPSDT. Service limits may be exceeded based upon medical necessity.

Medicaid does not reimburse for:

a. Services which do not meet medical necessity requirements.

b. Educational services being provided under an Individualized Education Program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA).

c. Custodial care, child care, and/or respite care services.

d. Treatment whose purpose is vocational or recreational.

e. Services, supplies, or procedures performed in a non-conventional setting including but not limited to: Resorts, Spa, and Camps.

f. Care coordination and treatment planning.

g. Duplicative services.

Provider Qualifications

To be recognized and reimbursed for intensive behavior intervention, the provider must be one of the following:

a. Licensure as a Physician by the Nevada State Board of Medical Examiners and acting within their scope of practice.

b. A doctoral degree in psychology obtained from an approved doctoral program in psychology accredited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the Nevada State Board of Psychologist Examiners. Licensed in the state in which they perform the functions or actions, and acting within their scope of practice.

c. A qualified Behavior Analyst (BCBA/D) is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certification as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the Nevada State Board of Psychologist Examiners, and acting within their scope of practice as defined by state law.

d. A qualified Assistant Behavior Analyst (BCaBA) is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education approved by the Board and holds a current certification as a Board Certified Assistant Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the Nevada State Board of Psychologist Examiners, and acting within their scope of practice. All BCaBAs must practice under the supervision of a Licensed Psychologist or BCBA/D. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

e. A Registered Behavior Technician (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the Behavior Analyst Certification Board, and acting within their scope of practice. All RBTs must practice under the supervision of a Licensed Psychologist, BCBA/D, or BCaBA. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

4.c. Family planning services are not covered for individuals whose age or physical condition precludes reproduction. Tubal ligations and vasectomies to permanently prevent conception are not covered for anyone under the age of 21 who is adjudged mentally incompetent or who is institutionalized.

5.b. Medical and surgical services provided by a dentist are limited to providers who are a doctor of dental medicine or dental surgery. Reference 42 CFR 440.50 (b) for further information.

6.a. Podiatrists' services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.

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b. Optometrists' services.

XX Provided: __ No limitations X With limitations*

__ Not provided.

c. Chiropractors' services.

XX Provided: __ No limitations X With limitations*

__ Not provided.

d. Other practitioners' services.

XX Provided: Identified on attached sheet with description of limitations, if any.

__ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: __ No limitations X With limitations*

b. Home health aide services provided by a home health agency.

Provided: __ No limitations X With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: __ No limitations X With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

XX Provided: __ No limitations X With limitations*

__ Not Provided.

8. Private duty nursing services.

XX Provided: __ No limitations X With limitations*

__ Not Provided.

*Description provided on Attachment 3a.

6.b. Optometrist services require prior authorization from the Nevada Medicaid Office. Refractions are limited to one in 24 months except for those required as a result of an EPSDT examination.

6.c. Chiropractor services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.

6.d. Other practitioner services

Physician Assistants' services are limited to the same extent as are physicians' services.

Advanced Practice Registered Nurses' services are limited to the same extent as are physicians' services.

Psychologists' Services must be prior authorized by the Medicaid Office on Form NMO-3 and normally are limited to 24 one-hour individual therapy visits per year. Any limitation of services for children under age 21 will be exceeded based on medical necessity for EPSDT services.

Community Paramedicine services:

1. The Division of Health Care Financing and Policy (DHCFP) provides coverage for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services (Emergency Medical Technician, Advanced Emergency Medical Technician, Paramedic, or Community Paramedic) fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.

2. Services must be part of the care plan ordered by the recipient's primary care provider. The primary care provider consults with the ambulance service's Medical Director to ensure there is no duplication of services.

A) The following services are covered under the supervision of the Medical Director:

a. Evaluation/health assessment.
b. Chronic disease prevention, monitoring and education.
c. Medication compliance.
d. Immunizations and vaccinations.
e. Laboratory specimen collection and point of care lab tests.
f. Hospital discharge follow-up care.
g. Minor medical procedures and treatments within their scope of practice as approved by the Community Paramedicine Agency's Medical Director.
h. A home safety assessment.
i. Telehealth originating site.

B) The following are non-covered services:

a. Travel time.
b. Mileage.
c. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital.
d. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code.
e. Duplication of services.
f. Personal care services.

7. Home health care services

Services: As regulated under 42 CFR 484, 42 CFR 440.70 and other applicable state and federal law or regulation.

Home health services are provided to a recipient at his place of residence, certified by a physician and provided under a physician approved Plan of Care. The provider must be enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home. Home health services include the following services and items:

a. Physical therapy.
(Reference section 11 "a" of Attachment 3.1-A)

b. Occupational therapy.
(Reference section 11 "b" of Attachment 3.1-A)

c. Speech therapy.
(Reference section 11 "c" of Attachment 3.1-A)

d. Family planning education.

Home health agencies employ registered nurses to provide postpartum home visiting services to Medicaid eligible women.

Provider Qualifications:

(Reference section 7 "e" of Attachment 3.1-A)

e. Skilled nursing services (RN/LPN visits)

Services of a registered or licensed practical nurse that may be provided to recipients in a home setting include:

"Skilled nursing" means assessments, judgments, interventions, and evaluations of intervention, which require the training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to performing assessments to determine the basis for action or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; central venous catheter care; mechanical ventilation; and tracheotomy care.

Provider Qualifications:
A "qualified registered nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

1. In addition to those requirements contained in NRS 632, an applicant for a license to practice as a registered nurse must:
   a. Have graduated from a nursing program approved by the Board.
   b. Have successfully completed courses on the theory of and have clinical experience in medical-surgical nursing, maternal and child nursing and psychiatric nursing if the applicant graduated from an accredited school of professional nursing after January 1, 1952.
   c. On or after July 1, 1982, obtain a passing score as determined by the Board on the examination for licensure.

   A "qualified licensed practical nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

2. An applicant for a license to practice as a licensed practical nurse must:
   a. Have graduated from high school or passed the general educational development test.
   b. Have graduated or received a certificate of completion from a program for registered nurses or practical nurses approved by the Board.
   c. Have successfully completed a course of study on the theory of and have clinical practice in medical-surgical nursing, maternal and child health nursing and principles of mental health if the applicant graduated from an accredited school of practical or vocational nursing after January 1, 1952.
   d. Obtain a passing score as determined by the Board on the examination for licensure.

f. Home health aide services.

Home health aides may provide assistance with:

1. Personal care services, such as bathing
2. Simple dressing changes that do not require the skills of a licensed nurse
3. Assistance with medications that are self administered
4. Assistance with activities that are directly supported of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise
5. Routine care of prosthetic and orthotic device

6. Monitoring of vital signs
7. Reporting of changes in recipient condition and needs
8. Any task allowed under NRS 632 and directed in the physician's approved plan of care.

Provider Qualifications:
A person who:

- has successfully completed a state-established or other training program that meets the requirements of 42 CFR 484.36(a); and
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b), or
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b) or (e).

An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individuals most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.

g. Medical supplies, equipment, and appliances suitable for use in the home.

Services:
Durable Medical Equipment (DME) is defined as equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Disposable medical supplies are those items which are not reusable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an illness or injury.

Service limitations:
Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Deluxe equipment will not be authorized when it is determined a standard model will meet the basic medical needs of the recipient. Items classified as educational or rehabilitative by nature are not covered under this benefit. The DME provider is required to have documentation of physician's orders prior to the dispensing of any equipment or supplies.

DME services are typically not covered under this program benefit for recipients in an inpatient setting. Customized seating systems may be covered under this benefit to a recipient in a nursing facility if the item is unique to their medical needs. Disposable services are not covered in an inpatient setting under this benefit.

Prior authorization and service limitations are applicable for some equipment and supplies. Specific limitations can be found in Chapter 1200 of the Medicaid Services Manual.

Provider Qualifications:
Providers are required to have a Medical Device Equipment and Gas licensure from the Nevada Board of Pharmacy

8. Private duty nursing services

Private duty nursing services means nursing services provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician. These services are provided in the recipient's home. To qualify for these services, a recipient must require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided in accordance with 42 CFR 440.80 and other applicable state and federal law or regulation. These services are offered through a home health provider that is enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home.

Provider Qualifications:
(Reference section 7 "e" of Attachment 3.1-A)

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

X Provided: _ No limitations X With limitations*

_ Not provided.

10. Dental services.

X Provided: _ No limitations X With limitations*

_ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: _ No limitations X With limitations*

_ Not provided.

b. Occupational therapy.

X Provided: _ No limitations X With limitations*

_ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: _ No limitations X With limitations*

_ Not provided.

*Description provided on Attachment.

9. Clinic services are subject to the same limitations listed elsewhere in this Attachment, e.g., limits on prescriptions and physician office visits.

10. Dental services are limited to emergency care only. Requirements for prior authorization for oral surgery are specified in the Medicaid Services Manual, Chapter 1000, Addendum A. For those individuals referred for diagnosis/treatment under the Early Periodic Screening, Diagnosis and Treatment Program dental services are not so limited, and the full range of dental care is provided without authorization. Orthodontics through EPSDT require prior authorization.

11a. Physical therapy provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(a) and other applicable state and federal law or regulation.

Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified physical therapist to ameliorate/improve neuromuscular, musculoskeletal and cardiopulmonary disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Physical Therapy Evaluations and Treatments: includes assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the recipient receiving treatment such as:

a. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments affecting areas such as tone, coordination, movement, strength, and balance;
b. Therapeutic exercise;
c. Application of heat, cold, water, air, sound, massage, and electricity;
d. Measurements of strength, balance, endurance, range of motion;
e. Individual or group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified physical therapist" is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State.

Physical therapy assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing (NRS 640.260), and has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977. PTA works under the direct supervision of the PT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient physical therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

The physical therapist must be present or readily available to supervise a physical therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11b. Occupational therapy services provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(b) and other applicable state and federal law or regulation.

Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Occupational Therapy Evaluations and Treatments: Include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services, such as:

a. Evaluation and diagnosis to determine the extent of disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
b. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;
c. Exercise to enhance functional performance;
d. Individual and group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified occupational therapist" is an individual who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

Occupational therapy assistant is a person who has satisfied the academic requirement of an educational program approved by the Board of Occupational Therapy and the American Occupational Therapy Association and is authorized (licensed or certified) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration. OTA works under the direct supervision of the OT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient occupational therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.

The occupational therapist must be present or readily available to supervise an occupational therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11c. Services for individuals with speech, hearing, and language disorders provided in an outpatient setting

Services: as regulated under 42 CFR §440.110(c) and other applicable state and federal law or regulation.

Speech and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist. Services are provided to a recipient to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Service limits may be exceeded based on medical necessity.

The practice of audiology consists of rendering services for the measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing. Audiology services must be performed by a certified and licensed audiologist. Treatment services such as:

a. Speech and language evaluations and diagnosis of delay and/or disabilities to include voice, communication, fluency, articulation, or language development;
b. Individual treatment and therapeutic modalities and/or group treatment (therapy);
c. Audiological evaluation and diagnosis to determine the presence or extent of hearing impairments;
d. Complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

Speech and language pathologist's are required to have a State license or State certification or registration and have a certificate of clinical competence from the American Speech and Hearing Association (ASHA); have completed the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

A qualified audiologist has a master's or doctoral degree in audiology which meets State licensure requirements. Per NRS 637B.160 they are licensed by the Board of Examiners for Audiology and Speech Pathology.

STATE Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

X Provided __ No limitations X With limitations*

__ Not Provided

b. Dentures.

X Provided __ No limitations X With limitations*

__ Not Provided

c. Prosthetic devices.

X Provided __ No limitations X With limitations*

__ Not Provided

d. Eyeglasses.

X Provided __ No limitations X With limitations*

__ Not Provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services..

X Provided __ No limitations X With limitations*

__ Not Provided

*Description provided on Attachment.

12. a.

1. Nevada Medicaid will meet all reporting and provision of information requirements of section 1927(b)(2) and the requirements of subsections (d) and (g) of Section 1927.

2. Covered outpatient drugs are those of any manufacturer who has entered into and complies with an agreement under section 1927(a), which are prescribed for a medically accepted indication (as defined in subsection 1927(k)(6)) of Title XIX of the Social Security Act.

1935(d)(1) 3. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2)
1935(d)(2) a. Other Drugs Not Covered:

1) Pharmaceuticals designated "ineffective" or "less than effective" (including identical, related, or similar drugs) by the Food and Drug Administration (FDA) as to substance or diagnosis for which prescribed.
2) Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed.
3) Pharmaceuticals manufactured by companies not participating in the Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY
12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit –Part D. ☐ **The following excluded drugs are covered:** *("All" drugs categories covered under the drug class)* ☐ *("Some" drugs categories covered under the drug class* ☐ *-List the covered common drug categories not individual drug products directly under the appropriate drug class)* *("None" of the drugs under this drug class are covered)* ☐ ☐ (a) agents when used for anorexia, weight loss, weight gain ☐ (b) agents when used to promote fertility ☐ (c) agents when used for cosmetic purposes or hair growth ☒ (d) agents when used for the symptomatic relief of cough and colds

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY
12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
	☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
	☒ (f) nonprescription drugs
	☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

3. The State will not pay for covered outpatients drugs of a non-participating manufacturer, except for drugs rated "1-A" by the FDA. If such a medication is essential to the health of a recipient and a physician has obtained approval for use of the drugs in advance of its dispensing, it may be covered by the program pursuant to section 1927(a)(3).

4. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication in accordance with the provisions of §1927 (d)(5) of the Social Security Act.

5. Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. The state, or the state in consultation with a contractor, may negotiate supplemental rebate agreements that will reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

6. Pursuant to section 1927(d)(6) the State has established a maximum quantity of medication per prescription as a 34 day supply.

   a) In those cases where less than a 30 day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

   b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30 day supply.

7. The state will meet the requirements of Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

   a) CMS has authorized the State of Nevada to enter into direct agreements with pharmaceutical manufacturers for a supplemental drug rebate program. The supplemental rebate agreement effective July 1, 2014 amends the original, January 1, 2012 version, which is effective through their expiration dates.

   b) Supplemental rebates received by the State under these agreements by the State that are in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

   c) All drugs covered by the program, irrespective of a supplemental agreement will comply with provisions of the national drug rebate agreement.

d) Any changes in supplemental rebate agreements should be submitted to the Centers for Medicare and Medicaid Services (CMS) for approval.

e) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).

f) Acceptance of supplemental rebates for products covered in the Medicaid program does not exclude the manufacturers' product(s) from prior authorization or other utilization management requirements.

g) Rebates paid under CMS-approved Supplemental Rebate Agreement for the Nevada Medicaid population does not affect AMP or best price under the Medicaid program.

8. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the Social Security Act.

9. Pursuant to Section 1927(d)(6) the State has established a maximum quantity of medication per prescription as a 34-day supply.

    a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

    b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.

12. b. Dentures are allowed every 5 years.

c. Prosthetic devices must be prescribed by a physician or osteopath and must be prior authorized by the Nevada Medicaid Office on Form NMO-3.

d. Eyeglasses are limited to those prescribed to correct a visual defect of at least 0.5 diopters or 10 degrees in axis deviation for recipients for recipients of all ages once in 12 months, or with prior authorization if program limitations are exceeded. In addition, they are available on the periodicity schedule established for EPSDT.

STATE Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

X Provided ___ No limitations X With limitations*

___ Not Provided

c. Preventive services.

X Provided X No limitations ___ With limitations*

___ Not Provided

d. Rehabilitative services.

X Provided ___ No limitations X With limitations*

___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided ___ No limitations X With limitations*

___ Not Provided

b. Nursing facility services.

X Provided ___ No limitations X With limitations*

___ Not Provided

*Description provided on Attachment.

A. Diagnostic Services. Provided under the EPSDT program.

B. Screening Services. Annual mammography provided to women aged 40 and over. Screening services also provided under the EPSDT program.

C. Preventive Services. Services provided are according to the United States Preventive Services Task Force (USPSTF) A and B recommendations along with approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP). Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing is not applied to any of these services.

D. Rehabilitative Services:

1. Mental Health Rehabilitation Services

Mental health rehabilitation assists individuals to restore and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically appropriate.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

Each individual service must be identified on a written rehabilitation plan. This is also referenced as the treatment plan. Providers are required to maintain case records. Components of the rehabilitation plan and case records must be consistent with the federal rehabilitation regulations. Rehabilitation services may only be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Services covered under the Title IV-E program are not covered under the rehabilitation program. Room and Board is not an allowable service under the mental health rehabilitative program. Services are not provided to recipients who are inmates of a public institution.

These services require utilization review according to the individual intensity of need and are time limited.

Rehabilitative mental health services may be provided in a community-based, outpatient services, home-based, and school-based environment. Depending on the specific services they may be provided in a group or individual setting. All collateral services that are delivered to a person that is an integral part of the recipient's environment such as medically necessary training, counseling and therapy, must directly support the recipient.

Services are based on an intensity of needs determination. The assessed level of need specifies the amount, scope and duration of mental health rehabilitation services required to improve, retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient.

Intensity of needs determination is completed by a trained Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associate (QMHA) and is based on several components related to person- and family-centered treatment planning. These components include:

- A comprehensive assessment of the recipient's level of functioning;
- The clinical judgment of the QMHP; or
- The clinical judgment of the case manager working under clinical supervision who is trained and qualified in mental health intensity of services determinations; and
- A proposed Treatment Plan.

A re-determination of the intensity of needs must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

Nevada Medicaid utilizes an intensity of needs grid to determine the amount and scope of services based upon the clinical level of care of the recipient. The grid is based upon the current level of care assessments: Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Services Intensity Instrument (CASII) for children. The determined level on the grid guides the interdisciplinary team in planning treatment.

Within each level there are utilization standards for the amount of services to be delivered. The six levels are broken out by the following categories in order from less intense to more intense;

Level of Care Utilization System (LOCUS)

- Level 1- Recovery maintenance and health management,
- Level 2- Low intensity community based services,
- Level 3- High intensity community based services,
- Level 4- Medically monitored non-residential services,
- Level 5- Medically monitored residential services, and
- Level 6 -Medically managed residential services.

Child and Adolescent Services Intensity Instrument (CASII)

- Level 1- Basic services, Recovery maintenance and health management,
- Level 2-Outpatient services,
- Level 3- Intensive outpatient services,
- Level 4- Intensive integrated services,
- Level 5- Non-secure, 24 hour services with psychiatric monitoring,
- Level 6- Secure, 24 hour services with psychiatric management.

All mental health rehabilitation services must meet the associated admission and continuing stay criteria and go through utilization management per the intensity of needs grid.

Service Array:

1. *Assessments: C*overed for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a Qualified Mental Health Professional or designated Qualified Mental Health Associate in the case of a Mental Health Screen. An assessment is not intended for entry into each of the services. It is provided as an overall assessment of the recipient's needs. Assessments are limited to two per calendar year. Additional assessments may be prior authorized based upon medical necessity. Re-assessments utilizing the appropriate CPT codes are not subject to the initial assessment limitations.

2. *Mental Health Screens*: Determine eligibility for admission to treatment program. This is completed through a clinical determination of the intensity of need of the recipient. The objective of this service is to allow for the 90 day review for the intensity of needs determination and to determine either SED or SMI if it has not already been determined. The provider must meet the requirements of a QMHA.

3. *Neuro-cognitive/psychological and mental status testing:* This service is performed by a QMHP. Examples of testing are defined in the CPT; neuropsychological testing,

neurobehavioral testing, and psychological testing. Each service includes both interpretation and reporting of the tests. This service requires prior authorization.

4. *Basic Skills Training*: Services in this category are rehabilitative interventions that target concrete skills training such as: monitoring for safety, basic living skills, household management, self-care, social skills, communication skills, parent education, organization skills, time management, and transitional living skills. This service is provided in a variety of settings including community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This service is provided by a QMHP or QMHA, under the direction of a QMHP, or provided by a QBA under the direct supervision of a QMHP or QMHA. This may be provided in a group (four or more individuals) or in an individual setting. These services require utilization review according to the individual intensity of need and are time limited.

5. *Psycho-social Rehabilitation*: Services in this category are rehabilitative interventions that target specific behaviors. These services may include: behavioral management and counseling, conflict and anger management, interpersonal skills, collateral interventions with schools and social service systems, parent and family training and counseling, community transition and integration, and self-management. This service is provided in a variety of settings including, community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This is provided on an individual basis or in a group consisting of at least four individuals. Service is provided by a QMHP or a QMHA. The services provided may be directly attributable to an individual provider. Recipients must either be severely emotionally disturbed or seriously mentally ill. The level of care of the recipient is consistent with the high intensity community based services. These services require utilization review according to the individual intensity of need and are time limited. This service is reimbursed in 15 minute increments.

6. *Crisis Intervention*: A service provided by a QMHP to recipients who are experiencing a psychiatric crisis and a high level of personal distress. Crisis intervention services are brief, immediate and intensive interventions to reduce symptoms, stabilize the recipient, restore the recipient to his/her previous level of functioning, and to assist the recipient in returning to the community as rapidly as possible, if the recipient has been removed from their natural setting. The individual demonstrates an acute change in mood or thought that is reflected in the recipient's behavior and necessitates crisis intervention to stabilize and prevent hospitalization. The Individual is a danger to himself, others or property or is unable to care for self as a result of personal illness. These services may be mobile and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody and homeless shelters. Crisis intervention services include follow-up and de-briefing sessions to ensure stabilization and continuity of care.

The service may be provided telephonically, as long as the service meets the definition of crisis intervention. Face to face crisis intervention is reimbursable for either one QMHP or a team that is composed of at least one QMHP and another QMHP or QMHA. This service is allowable for all levels of care. These services require utilization review according to the individual intensity of need and are time limited.

6. *Medication Management Training and Support* - Provided by a QMHP other than a physician. Typically this service is provided by a registered nurse. This service is for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). This service may be provided in the home and community-based program. This service is provided at all levels of care. This service is not the same as medication management that is provided by a physician under physician services.

7. *Mental Health Therapy:* Provided by a QMHP for individual, group, and/or family therapy with the recipient present and for family therapy without the recipient present. Therapy delivered must be of a direct benefit to the recipient. Minimum size for group therapy is three individuals and a maximum therapist to participant ratio is one to ten. Mental health therapy is billed utilizing the appropriate CPT codes for licensed professionals. Mental health therapy is available at all levels of care. The intensity of the service increases based on the need of the recipient. These services require utilization review according to the individual intensity of need and are time limited.

8. *Day Treatment Program*: A community-based psycho-social program of rehabilitative services designed to improve individual and group functioning for effective community integration. This is not an Institution for Mental Illness (IMD), a Residential Treatment Facility, nor is it an institution as defined under federal regulation. Admission to this program requires: severe emotional disturbance or serious mental illness and recipient's clinical and behavioral issues require intensive, coordinated, multi-disciplinary intervention within a therapeutic milieu. Day treatment is provided in a structured therapeutic environment which has programmatic objectives such as but not limited to: development of skills to promote health relationships and learn to identify ingredients that contribute to healthy relationships, development of coping skills and strategies, development of aggression prevention plans, problem identification and resolution, ability to learn respectful behaviors in social situations, development of the ability to demonstrate self-regulation on impulsive behaviors, development of empathy for peers and family and develop a clear understanding of recipients cycles of relapse and a relapse prevention plan. Services must be provided by a QMHP or by a QMHA under the direct supervision of a QMHP. The services provided may be directly attributable to an individual provider. The staff ratio is one to five participants. The average time per day this program is offered is three hours per day. Mental health therapy is a separate billable service under the appropriate CPT codes.

Mental health therapy and day treatment cannot be billed for the same time period. This service is consistent with intensive integrated outpatient services. These services require utilization review according to the individual intensity of need and are time limited. This service is reimbursed in hourly increments.

10. *Peer-to-Peer Support Services*: These supportive services assist a recipient and/or their family with accessing mental health rehabilitation services or community support services for needed stabilization, preventive care or crisis intervention. These services may include: empathic personal encouragement, self-advocacy, self-direction training, and peer recovery. These services must be a direct benefit to the recipient. Services may be provided in a group (requires five or more individuals) or individual setting. The services are identified in the recipient's treatment plan and must be provided by a Peer Supporter working collaboratively with the case manager or child and family team/interdisciplinary team. A minimum amount of services are offered based on the intensity of needs and prior authorization is required for utilization of services above the minimum amount. These services require utilization review according to the individual intensity of need and are time limited.

    A Peer Supporter is a qualified individual currently or previously diagnosed with a mental health disorder who has the skills and abilities to work collaboratively with and under the direct supervision of a QMHP in the provision of supportive assistance for rehabilitation services as identified in the treatment plan. Peer Supporters are contractually affiliated with a Behavioral Health Community Network, psychologist, or psychiatrists in order to be provided with medical supervision. Supervision by the QMHP must be provided and documented at least monthly. The selection of the Peer Supporter is based on the best interest of the recipient. The Peer Supporter must be approved by a QMHP. A Peer Supporter can not be the legal guardian or spouse of the recipient. A Peer Supporter must meet the minimum qualifications of a QBA.

Service Limitations

Rehabilitation mental health services are therapies or interventions identified in the treatment plan that are intended to result in improving or retaining a recipient's level of functioning. These services are person- and family-centered, culturally competent, and must have measurable outcomes. The amount and duration of the service is reflective of the intensity of needs determination of the recipient. Services require authorization through Nevada Medicaid's QIO-like vendor. The level of professional providing the service is dependent upon the needs of the recipient and the utilization management criteria.

Provider Qualifications

a. Qualified Mental Health Professional: A person who meets the definition of a QMHA and also meets the following documented minimum qualifications: 1) Holds any of the following educational degrees and licensure; Doctorate degree in psychology and license; Bachelor's degree in nursing, APN (psychiatry), graduate degree in social work with

the following: a graduate degree in counseling and a license as a marriage and family therapist, or a clinical professional counselor, or is employed by the State of Nevada mental health agency and meets class specification qualifications of a Mental Health Counselor. The following licensed interns are covered as a QMHP: Licensed clinical social worker intern, licensed marriage and family therapist intern, licensed clinical professional counselor interns, or a Psychological Intern registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

b. Qualified Mental Health Associate: A person who meets the following minimum documented qualifications; 1) Registered nurse OR 2) holds a bachelor's degree in a social services field with additional understanding of mental health rehabilitation services, and case file documentation requirements; AND 3) whose education and experience demonstrate the competency under clinical supervision to direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise, identify presenting problems, participate in treatment plan development and implementation, coordinate treatment, provide parenting skills, training, facilitate discharge plans, and effectively provide verbal and written communication on behalf of the recipient to all involved parties, AND 4) Has an FBI background check in accordance with the provider qualifications of a QBA.

c. Qualified Behavioral Aide: A person who has an educational background of a high-school diploma or GED equivalent. A QBA may only provide the following services: basic skills training and peer support services. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitation services which are under the direct supervision of a QMHP or QMHA, read, write and follow written or oral instructions, perform mental health rehabilitation services as documented in the treatment plan, identify emergency situations and respond accordingly, communicate effectively, document services provided, maintain confidentiality, successfully complete approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

(Reserved)

14. Services for individuals age 65 or older in institutions for mental diseases

A. Inpatient hospital services are limited to those certified for payment by a Professional Standards Review Organization. Inpatient psychiatric services are not to exceed five (5) days unless the attending physician documents why additional services are required. Emergency inpatient mental health services require no prior authorization. However, Medicaid's Peer Review Organization must be contacted for certification purposes within 24 hours or the first working day after the admission for certification purposes.

An emergency psychiatric admission must meet at least one of the following three criteria:

(1) Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 90 days; or

(2) Active suicidal ideation accompanied by physical evidence (e.g., a note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or

(3) Documented aggression within the 72 hour period before admission:

(a) Which resulted in harm to self, others, or property;

(b) Which manifests that control cannot be maintained outside inpatient hospitalization; and

(c) Which is expected to continue if no treatment is provided.

B. Nursing facility services require prior authorization from the Medicaid office on Form NMO-49.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services for MR (other than such services as in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

X Provided __ No limitations X With limitations*

__ Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

X Provided __ No limitations X With limitations*

__ Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

X Provided __ No limitations X With limitations*

__ Not provided

17. Nurse-midwife services.

X Provided __ No limitations X With limitations*

__ Not provided

18. Hospice care (in accordance with section 2302 of the Affordable Care Act).

X Provided X No limitations __ With limitations*

__ Not provided

*Description provided on Attachment.

15. a. Intermediate care facility services require prior authorization from the Institutional Care Unit on Form NMO-49.

16. Inpatient psychiatric facility services are limited to recipients under the age of 21 years if the admission is prior authorized by Medicaid's Peer Review Organization (PRO).

The only exception for the recipient to be admitted without a prior authorization would be in the event of an emergency in which the PRO must be notified within 24 hours or the first working day after the admission.

An emergency psychiatric admission must meet at least one of the following three criteria:

a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 90 days; or

b. Active suicidal ideation accompanied by physical evidence (e.g., note) or means to carry out the suicide threat (e.g., gun, knife or other deadly weapon); or

c. Documented aggression within the 72-hour period before admission:

1) Which resulted in harm to self, others, or property;

2) In which control cannot be maintained outside inpatient hospitalization; and

3) The aggression is expected to continue without treatment.

Inpatient psychiatric services are not to exceed five (5) working days unless the attending physician documents, on a daily basis, why additional services are necessary.

17. Nurse-midwife services are limited to the same extent as are physicians' services.

State/Territory: NEVADA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

__ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__ Provided: __ With limitations

X Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this Attachment and/or any additional services provided to pregnant women only.

*Description provided on Attachment.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

__ Provided: __ No limitations __ With limitations*

_X_ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: __ No limitations _X_ With limitations*

*Description provided on Attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

20. Extended services to pregnant women include all major categories of service provided for categorically needy recipients, except for services for individuals aged 65 or older in institutions for mental diseases, insofar as the services are medically necessary and related to the pregnancy. Services require prior authorization from the Nevada Medicaid Office on Form NMO-3.

    Expanded dental benefits are covered for pregnant women who are not normally covered for adult recipients ages 21 and older. In order to reduce the risk of premature birth due to periodontal disease, pregnant women will be allowed dental prophylaxes and certain periodontal services during pregnancy, as outlined within the Medicaid Services Manual, Chapter 1000, and the Provider Type 22 (Dentist) Fee Schedule, available on the Nevada Medicaid website, at http://dhcfp.nv.gov/.

22. All respiratory care services require prior authorization from the Medicaid Office on Form NMO-3.

23. Pediatric or family nurse practitioner services are limited to the same extent as physician services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a.1. Transportation

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

a.2. Brokered Transportation

☒ Provided: Under Section 1902(a)(70) ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

b. Services provided in Religious Health Care Institutions

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age

☒ Provided: ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

e. Emergency hospital services.

☒ Provided: ☒ No Limitations ☐ With Limitations
☐ Not Provided.

f. Personal care services in recipient home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

Covered under Item 26.

* Description provided on following pages

24.a.2. Brokered Transportation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: ____Nevada_____

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding "school-based" transportation.

☐ Not Provided:

☐ Provided without a broker as an optional medical service:
(**If** state attests "Provided without a broker as an optional medical service" **then insert** supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations.

Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

☒ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(**If** the State attests that non-emergency transportation is being provided through a brokerage program **then insert** information about the brokerage program.)

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)

☒ (10)(B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☒ stretcher car

☒ bus passes

☒ tickets

☒ secured transportation

☒ other transportation (if checked describe below other transportation).

- Charter air flight
- Commercial air
- Rotary Wing
- Fixed wing
- Ground ambulance
- Bus, local, city
- Bus, out of town

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (section 1931)

☐ Deemed AFCD-related eligibles

☒ Poverty-level related pregnant women

☒ Poverty-level infants

☒ Poverty-level children 1 through 5

☒ Poverty-level children 6 – 18

☒ Qualified pregnant women AFDC – related

☒ Qualified children AFDC – related

☒ IV-E foster care and adoption assistance children

☒ TMA recipients (due to employment) (section 1925)

☒ TMA recipients (due to child support)

☒ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☐ Optional poverty-level - related pregnant women
☐ Optional poverty-level - related infants
☐ Optional targeted low income children

- ☒ Non IV-E children who are under State adoption assistance agreements
- ☒ Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☐ Children aged 15-20 who meet AFDC income and resource requirements
- ☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☐ Individuals receiving COBRA continuation benefit
- ☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- ☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
- ☒ Individuals terminally ill if in a medical institution and will receive hospice Care
- ☐ Individuals aged or disabled with income not above 100% FPL
- ☐ Individuals receiving only an optional State supplement in a 209(b) State
- ☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
- ☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- ☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

☒ (i) risk capitation

☐ (ii) non-risk capitation

☒ (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

☒ (i) Broker

☐ (ii) State

☐ (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). For instance, the NET broker will facilitate rides for recipients requiring door-to-door transport (Paratransit). DHCFP will reimburse the Regional Transportation Commission (RTC) directly for any costs incurred for these services. This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provide to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☒ (7) The broker is a non-governmental entity:

☒ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

☐ Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

The NET broker provides transportation to and from medically necessary Nevada Medicaid covered services. Transportation is provided by the least expensive means available which is in accordance with the recipient's medical condition and needs and to the nearest appropriate Medicaid health care provider or medical facility. NET is available to all eligible Medicaid recipients with limitations.

Recipients call the NET broker for reservations. The NET broker verifies the recipient's eligibility and the existence of a medical services appointment. Recipients are screened for the most appropriate level of service. Recipients who use the system frequently or require high cost transportation may be further assessed by the Medicaid District Office to ensure appropriate utilization. The NET broker authorizes and schedules the rides with providers. The broker determines efficient routes.

The NET broker provides NET both statewide and out of state. Recipients traveling out of state may have the cost of meals and lodging en route to and from medical care, and while receiving medical care reimbursed. An attendant's costs may be covered if an attendant is required to ensure the recipient receives required medical services.

Medicaid does not reimburse the costs of non-emergency travel which had not been prior authorized or transportation to non-covered medical services. Ambulance charges for waiting time, stairs, plane loadings and in-town mileage and No shows, where a ride does not occur are also not reimbursable.

Full benefit dual eligible recipients may receive NET services to Access Medicaid only services.

Limitations:

Recipients whose eligibility is pending at the time of transport are not eligible for NET. QMBs and SLMBs for whom the State only pays their Medicare premiums are not eligible for NET. Emergency services only recipient may not receive NET for transport home from place of emergent services. Nursing facility NET for institutionalized recipients is included in NF rates. The NET broker may schedule rides for Paratransit services and the DHCFP will reimburse the RTC directly for any costs incurred.

Service Limitations

Recipients must contact the NET broker to obtain prior authorization for transportation in all but emergency situations. Medicaid does not reimburse the costs of: meals and lodging, transportation to non-covered medical services, ambulance charges for waiting time, stairs, plane loadings and in-town mileage, or non-emergency travel which had not been prior authorized. Medicaid does not reimburse the transportation of full benefit dual eligible Medicare Part D recipients for non-emergency travel which had not been authorized, transportation for non-covered prescription drugs, or non-emergency transportation for recipients whose eligibility is pending at the time of transport.

Provider Qualifications

To be a NET provider, a vendor must have a current provider agreement with Nevada Medicaid NET broker, a State issued exemption from TSA regulation, proof of a liability insurance policy, pursuant to NRS 706.291 for a similar situated motor carrier, a criminal background check and an alcohol and substance abuse testing program in place for the drivers, and vehicles adequately maintained to meet the requirements of the contract. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations.

24.d. Nursing facility services for patients under 21 years of age require prior authorization from the Nevada Medicaid Office on Form NMO-49.

24.f. Personal care services covered under item 26, page 10a.

State: NEVADA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided ___X___ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease that are: (1) authorized for an individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.

_X_ Provided: _X_ State Approved (Not Physician Service Plan Allowed)

_____ Not Provided: _X_ Services Outside the Home Also Allowed

_X_ Limitations Described on Attachment

State NEVADA

26a. Nevada Medicaid PERSONAL CARE SERVICES (PCS) assist, support, and maintain recipients living independently in their homes and in settings outside the home. These services are to be provided where appropriate, medically necessary, and consistent with program utilization control procedures. Personal Care Services may be an alternative to institutionalization. These services and hours are established based on medical necessity and must be prior authorized by Medicaid and established using a Medicaid defined functional assessment. Personal care services cannot exceed hours determined by a functional assessment conducted by State Medicaid staff or their designee. Services may be reassessed when a significant change in condition or circumstance occurs or annually as specified in policy.

Personal care services include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables them to accomplish tasks they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, and grocery shopping. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Personal care services may be provided by any willing and qualified provider through a Provider Agency (PA), Intermediary Service Organization (ISO), or by an Independent Contractor when a PA or ISO is not available in that area of the state. All providers must meet established qualifications of sixteen (16) hours of basic training, background checks, and TB testing. Legally responsible individuals (e.g. spouse, legal guardian, parent of minor child, legally responsible stepparent, or foster parent) may not be reimbursed for providing personal care services.

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Please describe any limitations:

1. Must meet applicable state licensing and/or certification requirements in the state in which the center is located. Services are limited to labor, delivery, post-partum, and immediate newborn care.

2. Accreditation by one of the following nationally recognized accreditation organizations:

   a. The Accreditation Association for Ambulatory Health Care, Inc.
   b. The Commission for the Accreditation of Birth Centers.
   c. The Joint Commission.

3. Service requirements are limited to care when the following pregnancy criteria are met:

   a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;
   b. Completion of at least 36 weeks' gestation and not more than 42 weeks' gestation.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)

☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Childbirth procedures are limited to labor, delivery, postpartum care and immediate newborn care.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs) and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: N/A